DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 08649
Registrar's No. 180

State of Maryland

1. PLACE OF DEATH:
(a) County Harford
(b) City or town Edgewood Arsenal (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Station Hospital, U. S. Army (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days) In this community 13 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Fort Hoyle (If outside city or town limits, write RURAL)
(d) Street No. Detachment, Q.M.C. (If rural, give location)
(e) If foreign born, how long in U. S. A.? - - - years.

3. (a) FULL NAME Arthur E. Bailey
3. (b) If veteran, name war World War
3. (c) Social Security No. - - -
4. Sex Male
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife - - -
6. (c) Age of husband or wife if alive - - years
7. Birth date of deceased September 6, 1884 (Month) (Day) (Year)
8. AGE: Years 55 Months 11 Days 13 If less than one day hr. - min.
9. Birthplace Fall River (City, town, or county) Mass (State or foreign country)
10. Usual occupation Soldier
11. Industry or business U. S. Army
MOTHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
FATHER
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)
16. (a) Informant's own signature Service Record, U.S.Army
(b) Address - -
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 20 8 1940 (Month) (Day) (Year)
(c) Place; burial or cremation Falls River, Mass.
18. (a) Signature of funeral director Howard K. McComas,
(b) Address Abingdon, Md.
19. (a) Aug. 30 (Date received local registrar) (b) Emily M. Shipley (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month August day 19 year 1940 hour 6:45 a.m. minute
21. I hereby certify that I attended the deceased from August 9, 1940, to August 19, 1940: that I last saw him alive on August 19, 1940: and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Apoplexy	
Due to	
Due to	
Other conditions 1. Myocardial insuffiency (Include pregnancy within 3 months of death)	
2. Hypertension, malignant.	
3. Myocardial disease	

Major findings:
Of operations None
Of autopsy Cerebral hemorrhage

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) -
(b) Date of occurrence -
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? - (Specify type of place)
While at work? - (e) Means of injury
23. Signature John F Breslin (M. D.)
Address Edgewood Arsenal, Md. Date signed 8/19/40

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08654

Reg. Dist. No. 18

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Henry Buchhanna

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Aug. 23 - 1940

8. AGE:

Years	Months	Days	If less than one day
still born			____ hrs. ____ min.

9. Birthplace: Aberdeen Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Miller Buchhanna
13. Birthplace: Perryman Md

MOTHER
14. Maiden name: Dorothy Hardy
15. Birthplace: Aberdeen Md

16. Informant: Mrs. Saddie Hubbard
Address: Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 27-1940 (month) (day) (year)
Cemetery or crematory: Union M.E. Cem
Location: Near Aberdeen

18. Funeral director: Henry Fanning & Sons
Address: Aberdeen Md.

19. Aug 24 1940 (Date rec'd by registrar) O.C. Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 23 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ____ 19__, to ____ 19__,
and that I last saw h alive on ____ 19__.

Immediate cause of death	DURATION
Stillborn	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Claude L. Cowan M. D. or other
Address: Havre de Grace Date signed: 8-24-40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121-C)

08651

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, Institution, or street address where death occurred:
Country Club Inn, Bel Air, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No. Country Club Inn
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Butterfield

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sara Wilson Butterfield deceased
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 23, 1862

8. AGE: Years 78 | Months 7 | Days 5 | If less than one day ..... hrs. ..... min.

9. Birthplace W Liberty, Ohio Co. - Virginia (Town, county, and state)

10. Usual occupation Retired - Hotel Proprietor

11. Industry or business

FATHER
12. Name John Butterfield
13. Birthplace Bingley, England

MOTHER
14. Maiden name Mary Watson
15. Birthplace Edinburg, Scotland

16. Informant Mary W. Reister
Address 1801 F St. N.W. Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 30, 1940 (month) (day) (year)
Cemetery or crematory Rock Spring
Location Forest Hill
18. Funeral director E. G. Kurtz & Son
Address Jarrettsville, Md.

19. Aug 30 1940 (Date rec'd by registrar) H. E. Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 1940, at 11:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1939 to Aug 28 1940
and that I last saw h... alive on Aug 28 1940

Immediate cause of death	DURATION
Due to Congestion of Lungs	
Due to Chronic Nephritis	
Other conditions Acute Dilatation of Heart	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. R. Richards M. D. or other
Address Bream Md Date signed Aug 29 40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

08652

CERTIFICATE OF DEATH

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town Aberdeen

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 24 yrs 11 mos

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Aberdeen Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. Edmund Est

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME Thomas Andrew Chase

3. (b) Social Security Number 705-09-9072

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6 (b) Name of ~~husband or~~ wife Catherine Chase

6(c) If alive, give age 22 years

7. Birth date of deceased (mo., day, yr.) Aug. 4th 1915

8. AGE: Years 24 Months 11 Days 21 If less than one day ____ hrs. ____ min.

9. Birthplace Aberdeen Md (Town, county, and state)

10. Usual occupation Day Laborer

11. Industry or business Aberdeen Proving Ground

FATHER 12. Name Mr. Andrew Chase

FATHER 13. Birthplace Charles Co Md

MOTHER 14. Maiden name Maggie Harvey

MOTHER 15. Birthplace Charles Co Md

18. Informant Mrs. Catherine Chase

Address Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 5. 1940 (month) (day) (year)

Cemetery or crematory Union M. E. Cemetery

Location Near Aberdeen Md

18. Funeral director Henry Fanning Sons

Address Aberdeen Md

19. Aug 3 1940 (Date rec'd by registrar) O.C. Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 1940, at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Drowning Accidental	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8/1/40

Where did injury occur? Near Aberdeen (City or town) Harford (County) Md. (State)

Injured at home, farm, industry, public place (where?) Creek

Means of injury Accidental Drowning Injured at work? No

23. SIGNATURE J. H. Lauer M.D. Dep. Med. Examiner

Address Aberdeen, Md. Date signed 8/1/40

RECEIVED
AUG 12 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (94a)

08653

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County: Harford.
City ~~or town~~: Havre de Grace, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 8 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County: Harford
City or town: Havre de Grace Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles E. Fallon.

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
male	white	widower.

6 (b) Name of husband or wife: —
6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 8, 1870

8. AGE:

Years	Months	Days	If less than one day
70	4	28	hrs. min.

9. Birthplace: Baltimore - Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER
12. Name: John C. Fallon.
13. Birthplace: Baltimore, Md.
MOTHER
14. Maiden name: Lillian Thelham.
15. Birthplace: Unknown.
16. Informant: Joe Fallon.
Address: Havre de Grace, Md.
17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof Aug. 9 1940. (month) (day) (year)
Cemetery or crematory: Hagel Hills
Location: Havre de Grace, Md.
18. Funeral director: Pennington & Son.
Address: Havre de Grace, Md.
19. Aug. 7 1940 (Date rec'd by registrar) James H. Bay M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 1940, at 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1940, to Aug 6 1940.
and that I last saw him alive on Aug 6 1940.
Immediate cause of death: Arthrio Sclerosis
Due to: Coronary Thrombosis
Due to:
Other conditions: Cardiac Failure
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Charles J. Foley M.D. M. D. or other
Address: Havre de Grace Md. Date signed 8/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08654

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A/5

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 18 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Bel Air Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Mr. William Henry Fraley

3. (b) Social Security Number: None

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Carrie L. Fraley
6(c) If alive, give age: / years
7. Birth date of deceased (mo., day, yr.): April 27 - 1872
8. AGE: Years: 68 Months: 2 3 Days: 8 If less than one day: hrs. min.
9. Birthplace: Harrisburg Pa (Town, county, and state)
10. Usual occupation: Accountant
11. Industry or business
FATHER 12. Name: Henry Fraley
13. Birthplace: Pa
MOTHER 14. Maiden name: Susan Strasbaugh
15. Birthplace: Pa
16. Informant: Mrs. Wm. H. Fraley
Address: Aberdeen Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 5-1940 (month) (day) (year)
Cemetery or crematory: Harrisburg Cemetery
Location: Harrisburg Pa.
18. Funeral director: Henry Fanning Sons
Address: Aberdeen Md
19. Aug. 3 1940 (Date rec'd by registrar) E. C. Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2nd 1940, at 2.55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28th 1940, to Aug 2nd 1940, and that I last saw h-- alive on Aug 2nd 1940.

Immediate cause of death: Lobar pneumonia — DURATION: 6 days
Due to:
Due to:
Other conditions: essential hypertension. cardiac enlargement.
(Include pregnancy within 3 months of death)
Major findings:
Ot operations: None
Ot autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Thos. P. Thompson M.D. (M. D. or other)
Address: Aberdeen, Md Date signed: Aug 3/40

RECEIVED
AUG 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

WITHIN CORPORATE LIMITS

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08655

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 556 Bourbon St.
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 556 Bourbon St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Baby Hill

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 10 1940

8. AGE:

Years	Months	Days	If less than one day
0	0	1	hrs. — min.

9. Birthplace Havre de Grace Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Cecil S. Hill
13. Birthplace Md.

MOTHER
14. Maiden name Ida M. Nelson
15. Birthplace Balto. Md.

16. Informant Cecil S. Hill
Address Havre de Grace, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 11, 1940 (month) (day) (year)
Cemetery or crematory Wesleyan Chapel
Location Harford Co. Md.

18. Funeral director R. Madison Mitchell
Address Havre de Grace, Md.

19. Aug 11 1940 (Date rec'd by registrar) James H. Bay M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 11, 1940, at 12 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10, 1940, to Aug 11 1940, and that I last saw him alive on Aug 11 1940.

Immediate cause of death Patent Foramen Ovale — DURATION

Due to —

Due to —

Other conditions —
(Includs pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Frank Wolbert M.D.
M. D. or other
Address Havre de Grace Date signed Aug 11

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

08656

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Aberdeen
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Dublin Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION) Rt 5
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John L Hill

3. (b) Social Security Number 082-07-7042

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Married

8 (b) Name of husband or wife: Emma Hill

Alive 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 29 1890

8. AGE: Years 49 | Months 11 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Harford Co., Md (Town, county, and state)

10. Usual occupation: Construction Foreman

11. Industry or business: Telephone Co.

FATHER 12. Name: John C Hill

13. Birthplace: Cecil Co., Md

MOTHER 14. Maiden name: Malissa Joner

15. Birthplace: Harford Co., Md

16. Informant: Mrs John L. Hill

Address: Darlington Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year): Aug 13 1940

Cemetery or crematory: Dublin Cem

Location: Harford Co., Md

18. Funeral director: H L Bailey

Address: Darlington Md.

19. Aug 10 1940 (Date rec'd by registrar) A. C. Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 10th 1940, at 7.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7.15 P M Aug 10 1940, to 7.45 P M Aug 10 1940, and that I last saw h- alive on Aug. 10/40 19

	DURATION
Immediate cause of death: Angina Pectoris	
Due to (a) history of anginal pain in the morning - fatal attack starting 6.30 P.M. Aug 10/40	
Due to (b)	
Other conditions: Hypertension	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Thos. P. Thompson M.D
M. D. or other
Address Aberdeen, Md Date signed Aug 10/40

RECEIVED
AUG 27 1940
BUREAU V. M.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

08657

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 105 No. Washington St.
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 45 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havred Grace Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 105 No. Washington St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME George Warren Hughes

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Laura A. Hughes
6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1868

8. AGE:

Years	Months	Days	If less than one day
72	5	14	— hrs. — min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Retired 18 mo.
11. Industry or business Jeweler
FATHER 12. Name Alfred Hughes
13. Birthplace unk.
MOTHER 14. Maiden name Martha Virginia Miller
15. Birthplace unk.
16. Informant Mrs. Laura A. Hughes
Address Havre de Grace, Md.
17. Burial Date thereof Aug 12, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace Md
18. Funeral director J. Madison Mitchell
Address Havre de Grace Md.
19. Aug. 12 1940 James H. Coy, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10, 1940, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Aug 10 1940, and that I last saw h— alive on Aug. 10, 1940.

Immediate cause of death	DURATION
Gastric Hemorrhage	
Due to Carcinoma of Stomach	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE [signature] M.D. or other
Address Havre De Grace Md Date signed 8/10/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-E)

08658

CERTIFICATE OF DEATH

Reg. Dist. No. 18 /

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town Near Aberdeen, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insf. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 2234 Eastern ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR World War

3. (a) FULL NAME Frank G. Jancewski

3. (b) Social Security Number 215-03-5857

4. Sex Mal

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Theresa Jancewski

6(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) Sept. 29 - 1899

8. AGE: Years 40 | Months 10 | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Davison Co

FATHER
12. Name Andrew Jancewskie
13. Birthplace Unknow

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Mrs. Theresa Jancewskie
Address 2234 Eastern Ave. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 6 1940 (month) (day) (year)
Cemetery or crematory St. Stanislaus Cem.
Location Baltimore City

18. Funeral director John M Debey
Address 401 S Chester St

19 Aug 5 19 40 (Date rec'd by registrar) O.C. Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 19 40, at 3:10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death	DURATION
Thoracic and abdominal Hemorrhage	
Due to Crushing wounds of Chest & abdomen	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8/2/40
Where did injury occur? Near Aberdeen (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?) Route 40
Means of injury auto accident Injured at work? yes

23. SIGNATURE J. H. Lammer M.D.
Dep. medical Examiner
Address Aberdeen, Md. Date signed 8/2/40

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BUREAU V. S.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 08659 183

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: 662 Green St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 662 Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME Mable Irene Jones

3.(b) Social Security Number —

4. Sex: ~~Male~~ Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Armon F. Jones
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.): Dec. 21, 1875

8. AGE: Years 64 | Months 7 | Days 15 | If less than one day — hrs. — min.

9. Birthplace Harford Co. Md. (Town, county, and state)
10. Usual occupation Home Duties
11. Industry or business Home
FATHER 12. Name Geo. T. Hopkins
13. Birthplace Md.
MOTHER 14. Maiden name Annie M. McCummings
15. Birthplace Pa.
16. Informant Mr. Norman E. Hopkins
Address Havre de Grace, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8, 1940 (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace
16. Funeral director P. Madison Mitchell
Address Havre de Grace Md.
19. Aug. 7 1940 (Date rec'd by registrar) James H. Bay M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 5 1940, at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated: That I attended deceased from 7-8 1940, to Aug. 5, 1940
and that I last saw her alive on Aug 5 1940

Immediate cause of death	DURATION
Acute dilatation of heart	
Due to Chronic Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M.D. or other
Address Havre de Grace Md. Date signed 8/6/40

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SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-9)

CERTIFICATE OF DEATH

08660

Reg. Dist. No. 181

1. PLACE OF DEATH:
County: Harford
City or town: Aberdeen
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 39 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Aberdeen Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: none

3. (a) FULL NAME: W. Linwood Loflin

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife: Ethel Palma Loflin

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 24th 1879

8. AGE:

Years	Months	Days	If less than one day
61	1	7	hrs. min.

9. Birthplace: Harford Co. Md
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: "

FATHER
12. Name: Wm Putnam Loflin
13. Birthplace: Harford Co Md

MOTHER
14. Maiden name: Sophia J. James
15. Birthplace: Harford Co Md

16. Informant: Mrs. Lucy L. Asher
Address: Aberdeen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 2 1940 (month) (day) (year)
Cemetery or crematory: Bakers
Location: Aberdeen Md

18. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md

19. Sept. 1 1940 (Date rec'd by registrar) O. C. Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 31 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 27 1939, to Aug. 31 1940, and that I last saw h- alive on Aug. 31, 1940.

Immediate cause of death: Carcinoma of Lung — DURATION 1 1/2 yrs
Due to:
Due to:
Other conditions: Generalized Arteriosclerosis
(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: J. H. Ramsey M. D.
M. D. or other
Address: Aberdeen, Md. Date signed 8/31/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS A15

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BUREAU V. S.

08661

STATE OF MARYLAND—CERTIFICATE OF DEATH

117-a

1. PLACE OF DEATH

County Harford Registration Dist. No. 183

Village or City Pylesville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME Robert Lee Linkous If U. S. Veteran, specify WAR

(a) Residence: No. Pylesville St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Linkous

6. DATE OF BIRTH (month, day, and year) Feb 15 1866

7. AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	74	5	19	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) June 1, 1940

11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (city or town) (State or country) Fayetteville Co Va

FATHER

13. NAME Wm P Linkous

14. BIRTHPLACE (city or town) (State or country) Montgomery Co Va

MOTHER

15. MAIDEN NAME Mary Cecil

16. BIRTHPLACE (city or town) (State or country) Montgomery Co Va

17. INFORMANT (Address) Thomas P Linkous Pylesville Md

18. BURIAL, CREMATION, OR REMOVAL

Place Fawn Grove Pa Date Aug 5, 1940

19. UNDERTAKER (Address) F Howard Hoff Fawn Grove Pa

20. FILED Aug 5, 1940 Thomas R Brown Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH August (Month) 3 (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 29, 1940, to Aug 3, 1940

I last saw him alive on Aug 2, 1940; death is said to have occurred on the date stated above, at 4 a m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Internal hemmorhage	1 ok

Other Contributory Causes of importance: Ulcerated stomach

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ___

Nature of injury ___

24. Was disease or injury in any way related to occupation of deceased?

If so, specify ___

(Signed) Edward H Hyson M. D.

(Address) Fawn Grove, Pa

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

93-D

State File No. 08662
Registrar's No. 180

State of Maryland

1. PLACE OF DEATH:
(a) County Harford
(b) City or town Edgewood, Md. (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Station Hospital, U.S. Army (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Harford
(c) City or town Edgewood Arsenal, (If outside city or town limits, write RURAL)
(d) Street No. None (If rural, give location)
(e) If foreign born, how long in U. S. A.? 25 years.

3. (a) FULL NAME August Mack
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife Marie Mack
6. (c) Age of husband or wife if alive No years
7. Birth date of deceased May 30, 1857 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
83	2	7	hr. min.

9. Birthplace (Town unknown) Germany. (City, town, or county) (State or foreign country)
10. Usual occupation Machinist
11. Industry or business at Baltimore, Md.

FATHER
12. Name William Mack
13. Birthplace Germany (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Unknown
15. Birthplace Germany (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs. F.P. Palacky
(b) Address Edgewood Arsenal, Md.
17. (a) (Burial, cremation, or removal) (b) Date thereof Aug. 10, 1940 (Month) (Day) (Year)
(c) Place; burial or cremation Holy Redeemer Cem, Balto, Md.
18. (a) Signature of funeral director Frank J. Pipitone
(b) Address 2818 E. Balto Md
19. (a) Aug. 7 (Date received local registrar) (b) Emily M. Shipley (Registrar's signature)

MEDICAL CERTIFICATION

20. Date of death: Month August day 7 year 1940 hour 1 minute 37PM
21. I hereby certify that I attended the deceased from August 6, 1940, 19__, to August 7, 1940: that I last saw him alive on August 7, 1940: and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Congestive heart failure	Unknown
Other contributory causes:	
1. Hypertensive heart disease.	Unknown
2. Auricular fibrulation.	Unknown
3. Generalized arterio-sclerosis.	unknown

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury
23. Signature Harold E. Opsahl HAROLD E. OPSAHL, Capt. MC (M. D. or other)
Address Edgewood Arsenal, Md. Date signed 8/7/40

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16 (a)

08663

Reg. Diat. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Hrs
Hospital, institution, or street address where death occurred: Adams & Lewis St.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL and give nearest town)
Street No. Burns Court #6
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Richard Allen Matherly

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Aug. 2, 1940

8. AGE: Years	Months	Days	If less than one day
0	0	0	15 hrs. — min.

9. Birthplace Havre de Grace, Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Harvey A. Matherly
13. Birthplace Va.

MOTHER 14. Maiden name Ruth Shirley Babel
15. Birthplace Tex

16. Informant Mr. Harvey A. Matherly
Address Havre de Grace, Md

17. Burial Date thereof Aug. 3, 1940
(Burial, cremation, or removal. Which?) (Month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace, Md.

18. Funeral director R. Madison Mitchell
Address Havre de Grace, Md.

19. Aug 3 1940 James H. Bay M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2, 1940, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1940 to Aug 2 1940 and that I last saw him alive on Aug 2, 1940

Immediate cause of death: Massive Collapse of Lungs

DURATION

Due to
Due to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE F. W. Deaver, M. D. or other
Address Havre de Grace Date signed 8-3-40

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WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

08664

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:

County Harford

City or town Havre De Grace
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Harford Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 das. 3 hrs.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Cecil

City or town Port Deposit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR none

3. (a) FULL NAME John May.

3. (b) Social Security Number none

4. Sex male

5. Color or race negro

6. (a) Single, married, widowed, or divorced widowed

B (b) Name of husband or wife Trezolena Cornish May

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years about 67 years | Months | Days | If less than one day unknown hrs. min.

9. Birthplace Conowingo Cecil Co. Md.
(Town, county, and state)

10. Usual occupation Waiter

11. Industry or business

FATHER
12. Name Henry May
13. Birthplace Harrisburg Pa.

MOTHER
14. Maiden name Mary S. Peters
15. Birthplace Conowingo. Md.

16. Informant Hospital Records.
Address Havre De Grace Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 28, 40 (month) (day) (year)

Cemetery or crematory Cokesbury cem.

Location Port Deposit R.F.D.

18. Funeral director Lee a. Patterson
Address Perryville. Md.

19. Aug. 27 1940 (Date rec'd by registrar) James H. Bay M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 25 1940, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 23rd 1940, to Aug 25 1940, and that I last saw him alive on Aug 25 1940.

Immediate cause of death Perforated gastric ulcer

Due to

Due to Peritonitis

Other conditions Exhaustion

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. G. Steiner M. D. or other

Address Havre de Grace Date signed Aug 26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

08665

Reg. Dist. No. 181

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town War Aberdeen
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 29 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Harford
City or town Near Aberdeen Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Jackson Hill
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mrs. Winifred H. McCarney

3. (b) Social Security Number 219-09-0980

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6 (b) Name of husband ~~or wife~~: John B. McCarney
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): April 25 - 1911
8. AGE: Years 29 | Months 4 | Days — | If less than one day ____ hrs. ____ min.
9. Birthplace: Harford Co. Md (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Winfield Greenland
13. Birthplace: Harford Co. Md
MOTHER 14. Maiden name: Mary Baker
15. Birthplace: Harford Co. Md
16. Informant: Mrs. John B. McCarney
Address: Aberdeen Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 3 - 1940 (month) (day) (year)
Cemetery or crematory: Bakers
Location: Aberdeen Md
18. Funeral director: Henry Tarring & Sons
Address: Aberdeen Md.
19. Sept 2 1940 (Date rec'd by registrar) O. C. Michael Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 31 1940, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

Immediate cause of death: Shock — Hemorrhage Pleural + Peritoneal Cavity — DURATION
Due to: Gunshot wound
Due to: Chest + Abdomen
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Probable Homicide Date of 8/31/40
Where did injury occur? War Aberdeen (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?) House
Means of injury Shotgun Injured at work? No

23. SIGNATURE J. H. Carmen M.D.
Dep. Medical Examiner
Address Aberdeen, Md. Date signed 9/4/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

08666

Reg. Dist. No. 181

1. PLACE OF DEATH:
County Harford.
City or town near Aberdeen, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) all his life.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Harford.
~~City~~ or town Oakington. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. —
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME John J. McLaughlin.

3. (b) Social Security Number none.

4. Sex: male. | 5. Color or race: white. | 6.(a) Single, married, widowed, or divorced: Single.

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb. 1 — 1870.

8. AGE: Years: 70 | Months: 6 | Days: 6. | If less than one day: — hrs. — min.

9. Birthplace Principio Cecil Co., Md.
(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

FATHER
12. Name James McLaughlin.
13. Birthplace Ireland.

MOTHER
14. Maiden name Ellen Nellis.
15. Birthplace Ireland.

16. Informant Grace Poplar.
Address Havre de Grace, Md.

17. Burial — Date thereof Aug. 10, 1940.
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt. Erin Catholic Cem.,
Location Havre de Grace, Md.

18. Funeral director Pennington & Son.
Address Havre de Grace, Md.

19. Aug. 8 1940 O. C. Michael
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 7 1940, at 6 A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1940 to Aug 7 1940, and that I last saw h alive on Aug 7 1940.

Immediate cause of death	DURATION
Carcinoma of	
Due to Stomach	
Due to Carcinomatosis	
Other conditions Cachexia	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Charles J. Foley M D
M. D. or other
Address Havre de Grace, Md. Date signed Aug 8 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

08667

CERTIFICATE OF DEATH

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford

City or town Havre de Grace Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Jeniah Miller

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frances Miller

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Dec. 25 1843

8. AGE: Years 96 | Months 7 | Days 24 | If less than one day ___ hrs. ___ min.

9. Birthplace: Harford County

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER

12. Name: Unknown

13. Birthplace

MOTHER

14. Maiden name: Jane Dorsey

15. Birthplace: Maryland

16. Informant: Mrs. Stella M. Jones

Address: Havre de Grace, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof Aug. 20, 1940 (month) (day) (year)

Cemetery or crematory: Grand Hill

Location: Harford Co.

18. Funeral director: P. Madison Mitchell

Address: Havre de Grace Md.

19. Aug 19 1940 (Date rec'd by registrar) James H. Bay M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 18 1940, at 7:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1940, to Aug. 18 1940, and that I last saw him alive on Aug 17 1940.

	DURATION
Immediate cause of death: Cerebral hemorrhage	1940
Due to: Arteriosclerosis	1940
Due to: Malignant Hypertension	1940
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE Frank Wolbert M.D.

M. D. or other

Address Havre de Grace Md. Date signed

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (183)

08668185

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL NEAR and give town)
Street address, ~~hospital, or institution.~~ union avenue.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 15

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland, County Harford.
City ~~or town~~ Havre de Grace Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. union avenue.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Martin S. Robinson

3. (b) Social Security Number 213-14-3644.

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: Single -
6 (b) Name of husband or wife —
6(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) June 18 - 1885.

8. AGE: Years 55 | Months 1 | Days 23 | If less than one day ___ hrs. ___ min.

9. Birthplace Cambridge - Maryland.
(Town, county, and state)
10. Usual occupation Bridge worker -
11. Industry or business —

FATHER
12. Name L. Walter Robinson
13. Birthplace Cambridge - Md.

MOTHER
14. Maiden name Alice B. Barwick.
15. Birthplace Easton, Md.

16. Informant Mrs. Bertie Myers.
Address Havre de Grace, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof Aug. 14 40. (month) (day) (year)
Cemetery ~~or crematory~~ Angel Hill Cemetery.
Location Havre de Grace, Md.

16. Funeral director Pennington & Son.
Address Havre de Grace, Md.

19. Aug. 13 1940 (Date rec'd by registrar) James H. Bay M.D. Registrar

MEDICAL CERTIFICATION Between 12-1:00 AM

20. DATE OF DEATH August 11 1940, at ___ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19___, to ___ 19___, and that I last saw h___ alive on ___ 19___.

Immediate cause of death Drowning - accidental

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy None

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8/11/40
Where did injury occur? Havre de Grace (City or town) Harford (County) Md. (State)
Injured at home, farm, industry, public place (where?) River
Means of injury accidentally Fell in River Injured at work? Yes.

23. SIGNATURE J. H. Lamsey M.D. Dep. Medical Examiner
Address Aberdeen, Md. Date signed 8/12/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08669

Reg. Dist. No. 18 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: Harford Co Home

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Months

Hospital, Institution, or street address where death occurred:

Bel Air Md

How long in hospital or institution? 11 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: Abingdon Bel Air

(If outside city or town limits, write RURAL and give nearest town)

Street No. [illegible] Tollgate

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Charles Roubal

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mrs. Chas. Roubal

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 1- 1867

8. AGE: Years 73 | Months - 2 | Days - 18 | If less than one day: ..... hrs. ..... min.

8. Birthplace: Prague, Germany (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER 12. Name: Unknown

13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: John S. Waldhausen (son-in-law)

Address: 1602 N. Register St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/21/40 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Balto. Md.

18. Funeral director: Stewart & Mowen Co

Address: 108-10 North Ave. Balto. Md.

19. Aug 19 1940 (Date rec'd by registrar) M. E. Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19th 1940, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1940, to Aug 19 1940, and that I last saw him alive on Aug 17 1940

Immediate cause of death	DURATION
Coronary Thrombosis	20 hrs.
Due to:	
Due to:	
Other conditions: Pernicious Anemia	4 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill, Md. Date signed: 8/19/40

RECEIVED
AUG 24 1940
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

3/16/38 (13-E) 48671

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Harford

City or town: near Rocks

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15

Hospital, Institution, or street address where death occurred: ✓

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Harford

City or town: near Rocks Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓ (If rural, give LOCATION)

2.(a) If veteran, name war: ~~42-18-2666~~

3.(a) FULL NAME William McKinley Rutherford

3.(b) Social Security Number 212-18-2666

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Ruth DeLores Rutherford

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): January 18-1912

8. AGE: Years	Months	Days	If less than one day
28 ~~52~~	7	30 29	..... hrs. ..... min.

9. Birthplace: Grassy Creek N.C. (Town, county, and state)

10. Usual occupation: Farm Labor.

11. Industry or business

FATHER — 12. Name: J. H. Rutherford

13. Birthplace: N.C

MOTHER — 14. Maiden name: Bessie Cook

15. Birthplace: Va

16. Informant: Mrs Ruth D. Rutherford

Address: Rocks. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 31 1940 (month) (day) (year)

Cemetery or crematory: Center

Location: near Forest Hill Md

18. Funeral director: Deaver & Foster

Address: Bel Air Md

19. Aug 30 1940 (Date rec'd by registrar) M. E. Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 27, 1940 at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1, 1940, to Aug 27 1940

and that I last saw ~~him~~ alive on Aug 25 1940

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other

Address: Forest Hill Md Date signed: 8/27/40

RECEIVED
SEP 4 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

08671

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Norrisville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Norrisville Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sarah Ann Strawbridge

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ... years: none

7. Birth date of deceased (mo., day, yr.): Feb 22 1864

8. AGE: Years 76 Months 5 Days 19 If less than one day ... hrs. ... min.

9. Birthplace: Harford Co Md (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business

FATHER: 12. Name: Joseph Strawbridge

13. Birthplace: Md

MOTHER: 14. Maiden name: Sarah Myers

15. Birthplace: Yorkshire Pa

16. Informant: Mrs Roy Scott

Address: Four Fire Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 13 1940 (month) (day) (year)

Cemetery or crematory: Centre

Location: New York Pa

18. Funeral director: W Howard Webb

Address: Fairmount Fire Pa

19. Aug 13 1940 (Date rec'd by registrar) Thomas R Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 10 1940, at 6 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 6 1940, to Aug 10 1940 and that I last saw her alive on Aug 9 th 1940

Immediate cause of death: Cerebral Hemorrhage

Due to: Arterio Sclerosis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Evans M Freeman M. D. or other

Address: Stewartstown Pa Date signed: Aug 10 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

WITHIN CORPORATE LIMITS OF

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

08672

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Rural Havre de Grace Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Havre de Grace Md. R.D.
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Rural Havre de Grace Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. R.D.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Clara Augustus Turner

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	Black	Widowed

6 (b) Name of husband or wife Samuel Turner
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Nov. 28 1862

8. AGE: Years 77 | Months 8 | Days 9 | If less than one day ____hrs. ____min.

9. Birthplace Harford Co. Md. (Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business Home

FATHER 12. Name Charles Lee
13. Birthplace Md.

MOTHER 14. Maiden name Sarah Bowser
15. Birthplace Md.

16. Informant Mrs. Edith Dorsey
Address 320 Edward St, Chester Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9 1940 (month) (day) (year)
Cemetery or crematory Grace Hill
Location Harford Co. Md.

18. Funeral director R. Madison Mitchell
Address Havre de Grace Md.

19. Aug. 8 1940 (Date rec'd by registrar) James H. Bay, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 6, 1940, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to Aug 6, 1940, and that I last saw her alive on Aug 6, 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	8-6-40
Due to: Hypertension	7-1-40
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Claude Rowan M.D. M. D. or other
Address Havre de Grace Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

08673

CERTIFICATE OF DEATH

Reg. Dist. No. 183

1. PLACE OF DEATH:

County: Harford

City or town: Norrisville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Harford

City or town: Norrisville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Florence V. Urrey

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Robert M. Urrey

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): May 2 1876

8. AGE: Years: 64 Months: 3 Days: 6 If less than one day: hrs. min.

9. Birthplace: Norrisville Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER: 12. Name: Wm Duncan

13. Birthplace: Md

MOTHER: 14. Maiden name: Sallie Smith

15. Birthplace: Va

16. Informant: Poss Wiley

Address: Stewartstown Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11 1940 (month) (day) (year)

Cemetery or crematory: Norrisville

Location: Norrisville Md

18. Funeral director: W. Howard Webb

Address: Fair Grove Pa

19. Aug 11 1940 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 8 1940 at 12.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 to — 19

and that I last saw her alive on Aug 8 at 11 am 1940

Immediate cause of death was

Due to: Myocarditis (chronic)

Due to: Chronic Interstitial nephritis

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Evans M. Free Wm M. D. or other

Address: Stewartstown Pa Date signed: Aug 10 40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 4 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

08674

Reg. Dist. No. 182

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Harford
City or town: Forest Hill
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Harford
City or town: Bel Air
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Chandler L Vail

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Married

6.(b) Name of husband or wife: Cornelia Vail
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 17, 1851

8. AGE: Years	Months	Days	If less than one day
88	10	16	..... hrs. ..... min.

9. Birthplace: New Jersey (Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business:
FATHER 12. Name: Lindley M. Vail
13. Birthplace: New Jersey
MOTHER 14. Maiden name: Rachel Harned
15. Birthplace: New Jersey
18. Informant: Mr Elwood Vail
Address: Forest Hill Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Aug 5, 1940 (month) (day) (year)
Cemetery or crematory: Forest Hill cem.
Location: Forest Hill Md.
18. Funeral director: Chas E Gross
Address: Benson, Md.
19. Aug 3rd 1940 (Date rec'd by registrar) M E Richardson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2 1940, at 8:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1940, to Aug 2 1940
and that I last saw h~~e~~ alive on Aug 2 1940

Immediate cause of death: Generalized Arterio-Sclerosis — DURATION: >
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Willard P. Hudson M. D. or other
Address: Forest Hill Md Date signed: 8/3/40

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170c)

CERTIFICATE OF DEATH

08675

Reg. Dist. No. 185

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Harford

City or town Havre de Grace

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Harford Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Harford.

City or town Havre de Grace Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William Walker

3. (b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 27 1924.

8. AGE:

Years	Months	Days	If less than one day
15	11	26	hrs. min.

9. Birthplace Washington - D.C.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Harold W. Walker

13. Birthplace New York

MOTHER 14. Maiden name Barbara Robinson

15. Birthplace Baltimore Md.

16. Informant Mr. Dent Robinson

Address Washington D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 26 1940 (month) (day) (year)

Cemetery or crematory

Location Washington - D.C.

18. Funeral director Pennington & Son.

Address Havre de Grace md.

19. Aug 23 1940 (Date rec'd by registrar) James T. Bay M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 22 1940, at 11:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death	DURATION
Probable Fracture of Femoral Vertebra and Compression	
Due to Shock	
Due to auto accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Evasive

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8/22/40

Where did injury occur? Route 40, near Edgewood, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public Road.

Means of injury auto accident Injured at work? No

23. SIGNATURE J. H. Lamey M.D. Dep. Medical Examiner

Address Aberdeen, Md Date signed 8/22/40

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-L)

CERTIFICATE OF DEATH

08676

Reg. Diat. No. 183

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Harford
City or town White Hall R.F.D.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Harford
City or town Madonna Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sherwood O. Wills

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6 (b) Name of husband or wife Lida Estep

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 27 1871

8. AGE: Years 68 | Months 9 | Days 27 | If less than one day ____ hrs. ____ min.

9. Birthplace Cold River, W. Va
(Town, county, and state)

10. Usual occupation

11. Industry or business Coal miner

FATHER 12. Name James Wells
13. Birthplace unknown

MOTHER 14. Maiden name unknown
15. Birthplace unknown

16. Informant Mrs. Bertha M. Weitzenburger
Address White Hall R.F.D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27-1940 (month) (day) (year)
Cemetery or crematory Bethel
Location White Hall R.F.D.

18. Funeral director P. Markham Law
Address White Hall Md

19. Aug 27 1940 (Date rec'd by registrar) Thomas R. Brown Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 1940, at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21 1940 to August 24 1940, and that I last saw him alive on August 23 1940

	DURATION
Immediate cause of death Heart Failure	1 Year
Due to Hypertensive Cardiovascular disease	1933 / 2 years
Due to	
Other conditions Varicose ulcers	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Melissa N. Borden M.D.
M. D. or other
Address Jarrettsville Md Date signed 8/24/40

RECEIVED
SEP 4 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

08677

CERTIFICATE OF DEATH

Reg. Dist. No. 185

1. PLACE OF DEATH:
County Harford
City or town Havre de Grace
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution 303 Alliance St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Harford
City or town Havre de Grace Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 303 Alliance, St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Summerfield Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Cynthia Jane Wilson
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 22, 1855

8. AGE:

Years	Months	Days	If less than one day
84	7	23	— hrs. — min.

9. Birthplace Cecil Co. Md.
(Town, county, and state)
10. Usual occupation Sea Captain
11. Industry or business Retired

FATHER
12. Name Wm H. Wilson
13. Birthplace Md.

MOTHER
14. Maiden name Mary Eliz. Murphy
15. Birthplace Md.

16. Informant Mrs. Lida Broadwater
Address Havre de Grace, Md.

17. Burial Date thereof Aug. 18 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Angel Hill
Location Havre de Grace Md.

18. Funeral director T. Madison Mitchell
Address Havre de Grace Md.

19. Aug 17 1940 James N. Bay Md
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 14 1940, at 10 06 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 9 1939, to Aug 14 1940, and that I last saw him alive on Aug 14 1940

Immediate cause of death	DURATION
Coronary Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions Carcinoma of Lower Jaw	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T. N. Steiner
M. D. or other
Address Havre de Grace Md. Date signed 8-17-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
SEP 5 1940
BUREAU V. S.